Walla Walla Community College
Athletic Department

500 Tausick Way
Walla Walla WA 99362
Phone: 509.527.4306 Fax: 509.527.4321

PARENTS INSURANCE INFORMATION

Athlete's Name: _____ Date of Birth:_____

Sport(s): _____ (Circle) Male Female Student Phone # _____

We, as the School, do not have the option of waiving the requirement of filing with your group insurance.

Please note: Most employers' group insurance allows dependent coverage to be continued to age 26 if the dependent is a full-time student. **DO NOT drop dependent coverage** while your son/daughter is participating in intercollegiate athletics.

THE FOLLOWING INFORMATION & AUTHORIZATION MUST BE FULLY COMPLETED, SIGNED, & RETURNED TO:

Walla Walla Community College
Attn: Wanda Williams, Athletics
500 Tausick Way
Walla Walla WA 99362

NOTE:
Please attach a copy of both the front and back of your insurance card to this form.

Father's Name: _____ Date of Birth (if you are subscriber for insurance):_____

Home Address / City / State / Zip: _____

Home Phone: _____ Work Phone: _____

Employer's Name: _____

Name of Group Insurance Company: _____ Effective Date of Policy_ _____

Group Policy Number: _____ Subscriber ID # _____Phone Number: _____

Mailing Address for Claims: _____

Is your dependent covered under the above policy? YES ☐ NO ☐

Does your insurance require
1. Second opinion for surgery? YES ☐ NO ☐
2. Pre-authorization for services? YES ☐ NO ☐

Mother's Name: _____ Date of Birth (if you are subscriber for insurance): _____

Home Address / City / State / Zip: _____

Home Phone: _____ Work Phone: _____

Employer's Name: _____

Name of Group Insurance Company: _____ Effective Date of Policy_ _____

Group Policy Number: _____ Subscriber ID # _____Phone Number: _____

Mailing Address for Claims: _____

Is your dependent covered under the above policy? YES ☐ NO ☐

Does your insurance require:
1. Second opinion for surgery? YES ☐ NO ☐
2. Pre-authorization for services? YES ☐ NO ☐

Primary Care Provider (name and phone number) _____

_____ I hereby authorize a claim to be filed on my behalf under the above group medical policy in the event an athletic injury is sustained by my son/daughter named above.

_____ My son/daughter is **NOT** covered under my group insurance.

Signature of Parent: _____ **Date:** _____